DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MONROE PLACE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN 47403 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
STREET ADDRESS. CITY, STATE, ZIP CODE 2770 S. ADAMS RD BLOOMINGTON, IN 47403 SIMMARY STATEMENT OF DEFICIENCIES PREERY (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG. REQULATORY OR I.SC. IDENTIFYING INFORMATION) ROUD Bidg. 00 This visit was for a State Residential Licensure Survey. Survey dates: March 26 & 27, 2015 Facility number: 004016 AIM number: 004016 AIM number: N/A Survey team: Cheryl Mabry, RN-1C Suzie Worsham, RN Angela Patterson, RN Kim Gines, RN (3/27/2015) Census bed type: Residential: 40 Total: 40 Residential sample: 7 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 02, 2015; by Kimberly Perigo, RN. R 121 410 IAC 18.2-5-1.4(f)(1-4)	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					COMPLETED		
MONROE PLACE 2770 S ADAMS RD BLOOMINGTON, IN 47403			B. W	ING		03/27	/2015	
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R 121 410 IAC 16.2-5-1.4(f)(1-4)			-					
		2015, by Killiber	ily I ciigo, Kiv.					
	R 121	410 IAC 16.2-5-1	4(f)(1-4)					
								<u> </u>

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 5 State Form Event ID: VC6511 Facility ID: 004016 If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING		COMPLETED 03/27/2015			
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
MONROE PLACE					DAMS RD IGTON, IN 47403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
Bldg. 00	employee of a faci contact. The screet tuberculin skin test method (5 TU, PP positive reaction or result shall be reconstructed induration with the and by whom admassure the followin (1) At the time of equation (1) At the time of equation (1) annually thereafted personnel of facility tuberculosis. The famust be read prior work. For health can a documented test result during the months, the baselity should employ the first step is negative be performed one after the first step, testing will depend with tuberculosis. (2) All employees reaction to the skir have a chest x-ray laboratory examinated a diagnosis. (3) The facility shall of each employee employment-related (4) An employee wactive disease, (sy active tuberculosis is ruled to the skir have a chest x-ray laboratory examinated (4) An employee wactive disease, (sy active tuberculosis is ruled tuberculosis.	shall be required for each lity prior to resident en shall include a t, using the Mantoux D), unless a previously an be documented. The orded in millimeters of date given, date read, inistered. The facility must ag: employment, or within one employment, and at least or, employees and nonpaid ies shall be screened for first tuberculin skin test to the employee starting are workers who have not a negative tuberculin skin testing two-step method. If the are, a second test should (1) to three (3) weeks The frequency of repeat I on the risk of infection who have a positive on test shall be required to and other physical and actions in order to complete with symptoms or signs of a mptoms suggestive of an including, but not limited ight sweats, and weight permitted to work until ad out.	D 121		It is the intent of this communi	tv	04/17/2015
	Based on intervio	ew and record review,	R 121		It is the intent of thiscommuni	ty	04/17/2015

State Form Event ID: VC6511 Facility ID: 004016 If continuation sheet Page 2 of 5

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		B. W	ING		03/27/2015		
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					ADAMS RD		
MONRO	E PLACE			BLOOM	MINGTON, IN 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D.		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			
	the facility failed	d to ensure a two-step			that a health screen shall be		
	tuberculin skin t	est was timely completed		required for each employee prior			
		wly hired employees			toresident contact. The screen		
		perculin health screen.			shall include a tuberculin skin	4	
					test, using the Mantoux metho (5 TU, PPD), unless a previou		
	(Housekeeper #	1).			positive reaction can be	Siy	
					documented.The result shall b	e l	
	Findings include	e:			recorded in millimeters of		
					induration with the date		
	Review of Hous	ekeeper #1's employment			given,date read, and by whom		
	records on 3/27/	2015 at 9:00 a.m.,			administered as follows:		
	indicated a date of hire as 1/21/2015.				1.At the time of employment	or	
	indicated a date of fine as 1/21/2013.				within one month prior to		
					employment and at least annu	ally	
	Housekeeper #1 received a first step tuberculin test on 1/16/2015. The skin				thereafter, employees and	hi	
					nonpaid personnel of the facili shall be screened for	ties	
	test was read on	1/18/2015. The second			tuberculosis. The first tubercul	in	
	step tuberculin t	est was administered on			skin test must be read prior to		
	_	ead on 2/20/2015 (1			employee starting work. For		
	month).	oud on 2/20/2015 (1			health care workers who have	not	
	inontin).				had a documented negative		
		2/05/0015			tuberculin skin test result durir	•	
	_	riew on 3/27/2015 at			the preceding twelve months,		
		Administrator indicated			baseline tuberculin skin testing]	
	Housekeeper #1	did not receive a			should employ the two-step		
	tuberculin test fr	om a previous employer			method.If the first step is negative, a second test should	Lho	
		date of 1/21/2015. The			performed one to three weeks	i be	
	second step tuberculin test should have				after the first step. The frequer	ncv	
	_				of repeat testing will depend o	- ·	
	been given two weeks after the first tuberculin test was read. Housekeeper #1 did not have the second tuberculin test during the right time frame. On 3/27/2015 at 10:05 a.m., the				the risk of infection with		
					tuberculosis.		
					2.Employees who have a		
					positive reaction to the skin tes	st	
					shall be required to have a	.	
					chestx-ray and other physical		
		·			laboratory examinations in ord	er	
	Administrator indicated the facility did not have a policy related to employee				to complete a diagnosis.	tain	
					3.The community shall main a health record of each employ		
	tuberculin testing. The facility just				a nealth record of each employ	yee	

State Form Event ID: VC6511 Facility ID: 004016 If continuation sheet Page 3 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 03/27/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE S ADAMS RD	
MONROE PLACE				MINGTON, IN 47403	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	follows the state	guidelines.		that includes reports of all employment related health screenings. 4. An employee with symptor or signs of active disease, symptoms suggestive of active tuberculosis, including but no limited to, cough, fever, night sweats, and weight loss shall be permitted to work until tuberculosis is ruled out. 1. What action has been take to correct the deficient practice affected residents? No reside were found to have been affected in the received a first step tuberculose test on 01/16/2015 which was read on 01/18/2015. To ensue house keeper #1 received a second step tuberculin test of the right time frame the test was repeated with a first step tuberculin test completed on 03/27/2015 and read on 03/29/2015. A second step tuberculin test was given on 04/06/2015 and read on 04/08/2015. 2. How were others identified who have the potential to be affected identified? The Execution Director and/or designee and employee tuberculin records. Other employees were found be affected. 3. What measures or system changes were put into place the ensure this does not re-occur and calendar has been developed to track new hire	d d cutive ited No to nic to

State Form Event ID: VC6511 Facility ID: 004016 If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
			B. WING		03/27/2015
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
MONRO	E PLACE			MINGTON, IN 47403	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				tuberculinskin tests as well as	
				annual tuberculin skin tests to	
				ensure newly hired employees	
				receive a first and second step	
				tuberculin skin test and annual	
				tuberculin skin tests within the	
				time frames noted above.	
				1.How will the corrective acti	ons
				be maintained? Through the	
				Quality Checks process the	
				tuberculin tracking calendar an	
				employee health record will be	
				checked daily x 30 days, weekl	-
				90 days and monthly thereafte the Executive Director	i by
				and/orDesignee to ensure	
				continuing compliance.	
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